SOUTH DAKOTA DEPARTMENT OF
PUBLIC SAFETY
DRIVER LICENSING PROGRAM

VISION STATEMENT

Name of Applicant _____ DL# _____

Address _____ Birth Date _____

Phone Number_____ Email Address:_____

Permission is hereby granted for the release of the medical data below and other medical history applicable in my case to the South Dakota Department of Public Safety, Driver Licensing Program.

I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. Any false statement or concealment of any material facts subjects any license issued to immediate cancellation.

Applicant Signature _____ Date _____

EYE EXAMINATION: This portion must be completed by a licensed optometrist or ophthalmologist:
Please answer all questions (leave no blanks).

DISTANCE VISUAL ACUITY:	Both Eyes Together	Right Eye	Left Eye
Without Lenses	20/	20/	20/
With Present Lenses	20/	20/	20/
With Best Possible RX	20/	20/	20/

1. For best possible distance visual acuity have corrective lenses been prescribed? _____
2. Have the corrective lenses been dispensed? _____
3. Is there any difficulty seeing in dim light or at night? _____
4. Recommendation as to frequency of visual re-examination: 1 YR _____ 2 YR _____ 3 YR _____
5. Doctor's opinion regarding applicant's visual ability to drive safely:

    a. Without restrictions _____ b. With restrictions _____ c. Inadequate _____

    Recommended restrictions (check all that apply below):

    Corrective Lenses _____ Left Outside Rearview Mirror _____
    50 Mile Radius of Residence _____ No Driving Outside City Limits _____
    Daylight Only _____ Other _____

Does patient have any other visual deficiency which, to your knowledge, would prevent him/her from safely operating a motor vehicle? Yes _____ No _____ If yes, please explain _____
_____

Being a licensed optometrist or ophthalmologist, I certify that I have personally examined the eyes of the applicant named and a true record of this examination appears above.

Doctor's Name (Please Print Legibly) _____

Doctor's Address (Please Print Legibly) _____

Doctor's Phone Number _____Fax Number_____

Date of Exam (Vision Statements are honored for 6 months from the exam) _____

Doctor's Signature _____ Date _____

Return completed application to: Department of Public Safety, Driver Licensing Office, 118 W. Capitol Avenue, Pierre SD 57501 or fax to (605) 773-3018